MILL STREET PSYCHIATRIC
1404 SE Mill Street
FAX: 541-492-1339 Roseburg, OR 97470 PHONE: 541-492-1340

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

____DOB______________________________
Patient name

____ ____________________________ _________ _______________
Street Address City St ZIP

Phone____

____/____
Name of clinician and/or facility to whom records are to be sent or from whom records are requested

____
Address

Ph:____ FAX____

By **initialing** the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

________ Send information ________ Receive information

Date range_______________________ -_________________________ or ________**All Dates of Service**

________ *Mental health information and/or records ________ Progress notes ________ Laboratory reports

________ Patient Demographics ________ Pathology reports ________ Emergency and urgent care records

________ Clinic Records ________ Billing statements ________ Transcribed hospital notes

________ Psychotherapy notes ________ Diagnostic imaging reports ________ *Genetic testing information and/or records

________ *HIV-Positive test results and HIV diagnosis ________ *Other sexually transmitted diseases

________ *Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe:____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV-Positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

I understand that the only person or entity I am authorizing to use and/or disclose information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization.

____ DATE_________________________
Signature of patient or patient's legal representative

This Authorization will expire one year from date signed unless otherwise noted here:____

____ ________________________________
Print patient's name or name of patient's legal representative Relationship to patient

___ Patient's or legal representative's personal identification verified Records copied by____